Questions from 11/18/03 Cost Containment Information Session

1. Q: What is the current status of slot numbers being released? Especially for those consumers that have been waiting for months and have had to be put back on ICLB? A: Due to the current deficit we are not able to allocate any additional slots except what we have budgeted for 04 and 05. This may excludes some LOC codes.

2. Q: When we convert a person's services from Title XX to SSW – can Title XX continue to pay for non-waiver services such as sheltered industry? A: Yes

3. Q: Will consumers who live at home be able to move out of their parent's home on the waiver? A: No. If the situation becomes one in that a consumer's health and safety is at risk then a move may be warranted. We will look at this on a case-by-case basis. Contact your local BDDS office if you have a case that needs review.

4. Q: For specialized med equip – who gets the P.A.? A: The prior authorization can be done by the company the equipment is being purchased from. The therapist or physician can also submit the prior authorization if it is equipment he or she deems necessary. The approval or denial of the prior authorization needs to be kept in the consumers file by the case manager.

5. Q: What are you doing about those consumers (mostly children) that we as providers have lost so much in billing due to them being denied for AFC/CFC transitions on the ICLB? A: Children's Foster Care is not a service available on the waiver. This service needs to continue to be supported on the ICLB. If an adult was supposed to transition services to the Waiver as a part of the T05, state line item to waiver conversion project, but did not do to DDARS placing a hold on these CCBs, the provider may prepare an ICLB and back date accordingly. The provider should work with the local BDDS office and this may require data entry by BDDS Central Office.

6. Q: Re: Case management hours. It has previously been that case mgmt. Hours were an average of 6 hrs. Per month or no more than 72 per year. Are you saying case mgrs. need prior approval even if they go over 1 month, and adjust according to not go over 72? A: Case management is based on a rolling calendar year. The hours of case management may fluctuate from month to month as long as the total amount of hours budgeted on the CCB are not exceeded.

7. Q: Is TD1 (Transportation) allowed when a client is receiving IAS? A: Individuals receiving IAS services are eligible for T1st and T2nd transportation services.

8. Q: If we are to work so hard to contain cost, do you think that the state could work hard at making sure we get paid? At times compensation is running as low as 50% of services rendered. A: Yes, we are currently looking at all of the processes around payment. We realize this is an issue. If you have a waiver related billing issue please contact T.G. Williams at twilliams2@fssa.state.in.us.

9. Q: T05, does this refer to folks who are currently on state funds waiting to transition to SS waiver or DD waiver? A: Yes. The T05 LOC code is only for those who are currently served on an ICLB and are transitioning to the DD Waiver.

10. Q: With all these cost containment measures in place, it seems that the approval process will be even longer. How are providers expected to continue uninterrupted quality services when they are waiting 2-3 months for CCBS to be approved then finding out that the services have been changed or decreased? What attempts are you making to expedite the process? A: We feel that education is important. By providers, case managers and consumers being educated on the expectations and the saving guidelines in place, they will complete their budgets accordingly. This would include complete and accurate justification for additional services outside of the specified guidelines. Additionally we would say to start the budget process forty five days in advance so that will allow us a thirty day process time in case we need to communicate back and forth with the case manager.

11. Q: Suggestion: Can roommate hours be interchangeable to accommodate every day life? 1 roommate goes home, the other gets all the staff hours…no adjustments requested. Budgets (service planners) need to be looked at as a household. A: Presently, budgets need to continue to be developed on an individual basis. No decisions have been made to make any changes in this area; however, DDARS is exploring other options that may provide alternative billing methods.

12. Q: If we're making the adjustments this year to control the 21 million dollar deficit (this year) then why is next year's deficit projected to be nearly 42 million? A: The projections for 2004 and 2005 do not currently include any of the cost containment initiatives presented. We are focusing on the 2004 deficit and we understand that changes we make in FY04 will also affect FY05.

13. Q: What about people who absolutely cannot share an apartment with someone due to aggression or behaviors? A: A high cost review committee will be established to review any exceptions to the limits on a case by case basis.

14. Q: If ISPs and PCPs are not being implemented because the CCB's are denied or cut, then who is accountable? Q: Are person centered planning requirements being eliminated to reconcile with the mandated service limits? Q: With all the emphasis on PCP and ISP's, most teams feel this has become a wasted process and means nothing in providing services. When case managers' request changes and or increases: What changes do you suggest to improve morale on teams? A: PCPs and ISPs need to be developed with cost effectiveness in mind. Per Rule 460 IAC 7-3-12, PCP means a process that "c) is supported by a short term plan that is based on reasonable costs, given the individual support needs. It also states that the PCP includes a range of supports including funded, community and natural supports. ISPs need to be developed with appropriate supports identified for implementation.

15. Q: If a client is denied adequate staffing by the state and the individual has a bad thing happen because of staffing decrease, is the State liable? A: The states' responsibility is to respond to the justification for services. It is our financial and legal obligation to monitor the monies and support systems for individuals with disabilities, not to put anyone in harms way. Refer to BQIS recommendations and evaluation of staffing needs presented at 12/15/03 Provider Training.

16. Q: How does the state expect to encourage providers to remain waiver certified if reimbursement rates decrease? A: The reimbursement rates are not going to decrease at this time.

17. Q: If you have a 3-person waiver home how many staff hours in a 24-hour day? A: We estimate RHS should be 40 hours in a 24-hour day for a 3 person setting. This will be explained in detail in the RHS policy to be released 12/15/03.

18. Q: Can we have more informational meetings? A: Yes we will try to do on a quarterly basis and the next provider/case manager meeting is scheduled for 12/15/03.

19. Q: Re: Bottom Line. Are the projected deficits based on current spending or existing budgets? A: The projected deficits are based on actual expenditures.

20. Q: How can we get a copy of this PowerPoint presentation? Lots of info provided. A: It is available on our Web site at: http://www.in.gov/fssa/servicedisabl/

21. Q: Are slots still available for group home conversions? A: Group home conversions will be reviewed on a case by case basis and you should consult with the Bureau of Developmental Disabilities. The contact is Juman Bruce at jbruce@fssa.state.in.us.

22. Q: Sleep time. Is there any way more time can be given…March 1? To get the sleep time issue resolved?. A: No, there will not be an extension. This is a real liability issue and we need to have awake staff at work for the protection of clients, your protection, and ours.

23. Q: Group homes are available and an appropriate residential option. Why does it seem that BDDS does not support & promote this option? A: We do support this option, and we are planning to do some additional marketing to help fill group home beds. Group homes are a great alternative.

24. Q: Is there consideration made to cut/reduce case management? A: The current guideline of 6 hours/month is our policy. No other measures have been discussed at this time.

25. Q: Are W198's from group homes considered "emergencies? A: They are considered a category for a priority waiver. If the individual meets Level of Care as determined by OMPP and there is an available slot, they would qualify for a priority waiver slot. These must be requested through the local BDDS office.

26. Q: What is the plan on how to serve individuals with extremely aggressive behaviors? A: We are currently looking at ways we can facilitate more support systems for individuals with hard to manage behavior issues. As this system is developed we will further discuss options. We encourage the behaviorist to network and possibly seek other experts in the field for advice and guidance.

27. Q: What if the new limited hours do not protect the individuals or put their housemates at risk? A: We do not support putting individuals at risk or without needed supports. We will evaluate on an individual basis what those additional support needs are.

28. Q: Would an individual who is in need of day services but could not get admitted into a day program until 1 ½ year after the start of waiver services, be denied an increase in an updated CCB once a day service agreed to admit the individual? (Person is on SSW) A: The Individual Support Team would need to evaluate the situation. I could be that the participation in the day service may be able to replace other services previously provided at that time. The case manager should coordinate review of services for continued appropriateness and submit a revised budget with justifications.

29. Q: The biggest "waste" of a waiver service is the BMAN HSPP Level 1. Is there any consideration to eliminate this? They do nothing but collect money. A: We have not considered eliminating BMAN Level 1.

30. Q: Letters refer to memo of 9/11/03…please explain the recent requests to decrease SS waiver CCBs, even when services already in place are continued at the same levels. The only things creating the increase are case management (which started July '01) BMAN I, or services that started 1-2 months into the plan (due to providers securing staff, etc.) I have a plan denied, services continued at the same level and we even decreased one service, and it was still denied!!! How can case management be a justified reason to decrease other services? A: Support Services Waivers are being reviewed similarly to the Autism and DD Waivers. The $10/day or 10% guideline applies as well. The scenario as described should not have been denied. The actual case would need to be reviewed in more detail. Lilia Teninty may be contacted at lteninty@fssa.state.in.us for further review.

31. Q: Why do you not require DD waiver consumers to pay a portion of their costs with their own resources? A: It is a Medicaid rule that individuals cannot be required to pay for services that are fundable by Medicaid. Spend down is the only situation in which an individual is required to be responsible for a portion of Medicaid costs.

32. Q: Could we please have an updated organizational chart of who's who in waiver with phone numbers e-mail addresses, responsibilities? A: Yes, we will be distributing that at the 12/15/03 Provider Training.

33. Q: Define what therapeutic benefit is? A: Therapy is beneficial when an individual consumer is sustaining or gaining development in identified areas of needs by that therapist.

34. Q: Did you say that an individual on the support services waiver can only get 10 hours of supported employment hab a week? What if more is needed? A: The Waiver Specialists are using an average of 10 hours per month s a guideline for Supported Employment for the Support Services, Autism and DD waivers. This is consistent with the services available with Title XX. Additional hours are possible and the case manager must justify the need to exceed this average.

35. Q: Are you considering re-implementing the personal assistance category for general use, including job sites? A: No, not at this time.

36. Q: If BDDS is encouraging waiver folks to go seek day services, providers must have an adequate rate of services payment for these people. Currently group hab rates are paid @ a rate of $5.34/hr with a staff ratio of 8:1…this is not reasonable for many of the waiver folks who need higher support needs and more attention than 8:1 ratios…Adult Day Services has been looked @ by our agency as an option, but based on rate reimbursement we cannot afford to offer that service…how can this problem be addressed? A: This is of great concern to us, and we are looking at ways to make this more attractive so that more consumers will have an opportunity to get out of the home and work. We will keep everyone posted.

37. Q: How will field offices &/or state people be assured that providers don't change case managers in order to find a case manager who will maintain or increase a budget? A: The waiver specialists will be reviewing the budgets consistently which will not allow one case manager to obtain more services than another. Any increase above a certain dollar amount ($10 or 10%) will be flagged for review by a waiver specialist.

38. Q: How many months back can a CCB now be denied? What if the service has already been provided? Q: Will the provider be paid for services if there is a lag in CCB approval resulting in no POC? Q: We have not had some of POC's back due to various reasons. Will costs be cut even if the provider served the clients since June following the proposed POC and ISP? A: If a CCB has not been approved and new services have begun or services have increased, we may deny that CCB. If it is a matter of the annual being submitted after the previous had expired and there are not changes in the dollar amount of services, services will be maintained and the CCB will be approved with the annual CCB dates. The risk of not being reimbursed would be if the services are new or increased and not yet approved. We ask that case managers plan ahead. We recommend submitting a new CCB 6 weeks prior to expiration of previous CCB or change in services.

39. Q: Is there any possible way to expedite CCBs for individuals transferring from State Line funding to DD Waivers if they will be forced to go to different a doctor due to Medicaid Select. A: We are currently not processing Initial CCBs to transition individuals from State Line item to DD Waivers. Unfortunately, without the waiver, consumers on Medicaid will be transferred to Medicaid Select. This is an automatic system that cannot be changed. If T05 slots do become available again, contact would need to be made with the local DFC office to get this changed.

40. Q: What is the timeline for correcting the internal system issues with level of care and AIM to reduce claim denials for budgets that are approved? A: DDARS recognizes the need to examine this process; however, a time line has not yet been established to make any changes to the current system.

41. Q: How do we address using all of our CM hours doing revisions on the CCBs and justifying services? Or fixing all of the glitches on INsite? A: BDDS will be providing written guidelines with expectations for justification of services on December 15, 2003. Adherence to these expectations when submitting CCBs to the waiver specialists should significantly reduce the amount of MWURequests currently being generated.

42. Q: As a provider – I do not see the need to maintain a CCB only a NOA. What am I missing or why do we need it? A: As the provider of service, the only documentation required to be on file

is the Notice of Action. Some providers prefer to also have the CCB as a part of the consumer's record.

43. Q: Why does the state want to reduce family involvement in served hours? Many times they are the best staff? A: Family involvement is strongly encouraged in the lives of the individuals we serve. BDDS continues to allow parents and guardians of adults to be paid caregivers.

44. Q: 24 hour cases to 18 will cause provider to leave – how will that work? Q: Are you asking the provider to accept 24 hour responsibility for clients at 18 hours reimbursement? Is the provider going to be legally responsible for 24 hours? A: An individual may continue to require 24 hour services; however, a limit of 18 hours of RHS services for a one person setting is being recommended. This will encourage individuals and Individual Support Teams to pursue other options for the remaining hours to total 24 hours of support. These options may include activities such as day programs, employment, unpaid supports, housemates, family time, etc. There will be a process in place for allowing continued 24 hour RHS supports in certain circumstances.

45. Q: Why does the NOA have to be signed by the case manager? It means more paper and more tracking? A: The required signature is a check and balance in our system. It also is a requirement of CMS that this form be signed by the case manager to document and verify that what is included on the NOA is accurate.

46. Q: If an NOA is received from the state without an approval date – is this a mistake? Is it really approved – or why did we get it? A: A NOA should not be sent without an approval date. If this was generated, it was a mistake and should be addressed individually. Please contact Lilia Teninty at lteninty@fssa.state.in.us for further review.

47. Q: Will day programs get extra money short term (60-90) days to transition people into day program – behavior challenges etc. A: We currently do not have plans to pursue this option.

48. Q: If 2 consumers are living in the community and 1 wants to move out due to issues with the roommate and provider and his budget will not increase, will that individual be prevented from moving out if the roommate's budget is denied due to costs? Isn't this issue the provider's problem, as they would have to continue serving the roommate? A: Each situation would need to be reviewed on a case by case basis to determine the existence of any health or safety risk. A move may be delayed if health or safety issues are not involved. In addition, all associated costs for a move need to be examined. This includes not only service costs, but also any living expenses, such as increased rent, deposits, etc. The Individual Support Team must have the approval of the local BDDS office for any type of move. Budgets for 1:1 settings will likely be approved for a 90 day period. The case manager and provider would need to work together to locate a new housemate..

49. Q: What can be done to make the "waiver specialist" more helpful and less adversarial? The waiver case managers have had a lot to deal with, which has included some adversarial customers too. A: The current circumstances facing all of us are difficult for everyone involved, but we also expect our State employees to treat providers and case managers with respect. If you would like to report a specific incident please contact Lilia Teninty at lteninty@fssa.state.in.us.

50. Q: What about adding new services to a clients' budget? If the Inter Disciplinary Team feels a person really needs MT or PT – will the Medicaid specialist still deny? A: It is likely that the addition of any services that are not related to the health and safety of an individual will generate a MWURequest. The waiver specialists would ask the Individual Support Team to examine all the services on the CCB to determine if reductions may be made in other ares, so that there will not be an increase to the overall daily cost.

51. Q: Sharing services – can one respite worker provide respite services for more than one sibling at a time to share services? Example: 1 worker and 2 clients (siblings) for 4 hours while primary

caregiver is out of house. A: Yes. If there were two consumers sharing services for a 4 hour period, then each consumer would account for 2 hours of service.

52. Q: Is it no longer a client choice to live alone? Do they have to live with a housemate even if services increase to put 2 individuals together? A: A consumer may still choose to live alone, but may be able to be supported to maintain health and safety within the limits of RHS for a one person setting. The current revision proposed to the RHS would result in a reduction in RHS services when a housemate is added to the living arrangement.

53. Q: What is the backup plan by BDDS when a provider of CMGT, RHS or other supports runs out of contracted hours per the CCB? Will someone else provide the service? A: It is the responsibility of the provider to assume the appropriate services and supports are in place to assure the consumer's safety. The provider should communicate with BDDS the anticipated utilization of increased hours and initiate the completion of appropriate plans (CCB/ICLB).

54. Q: When will this information per service limitations and cost caps be available in writing so it can be shared with families and support teams? A: This information will be made available at the December 15, 2003 Provider and Case Manager training.

55. Q: There is a total lack of community mental health services. For inpatient psych. services, agencies are being required to staff 24 hours/day. Is this illegal and violating client rights? A: If inpatient psych. services request staff from agencies 24 hours a day, there are no obvious client right violations.

56. Q: Are there plans in the future to communicate policy changes through unified, "official" channels, rather than CCB comments by waiver specialists, along with ensuing rumors? A: Yes. BDDS is working on establishing a communication process for future changes and enlist the assistance of a small committee to review bulletins prior to being set out.

57. Q: If a CCB is only approved for 90 days due to no roommate, does this seem that CMs is also D/C'd after 90 days? A: Individual services may be end dated for 90 days. The expectation for this example would be to end date the RHS service.

58. Q: Regarding behavior management: Some consumers present significant risk of injury to self and others and cannot be supported with 6 hours. However, the rule requires BC's to stay on the case until someone else is hired. How can we be in compliance and ethically provide services if the budget is significantly reduced? A: The 6 hours per month of behavior support services is a guideline, not a cap. In cases requesting more than the 6 hours, the justification needs to include more detailed information about what specific activities are being performed for this service.

CHPI and RHS Questions:

We received several questions regarding CHPI and Residential Habilitation and Support. These services will be clarified at the December 15 Provider Training.

CHPI was originally intended to replace Day habilitation services being provided by Title XX providers. When this services was added to the waivers, Residential providers also starting adding this service to the CCB. The Community Habilitation and Participation service definition has not been changed. Previous CCBs have not been reviewed closely. Waiver specialists are not scrutinizing the justifications for this service with the following guidelines:

- 6 hours per week is an average amount of CHPI services. This is based on what was previously (and currently) allowed for someone receiving this service on Title XX. Any CCBs exceeding this amount may require additional justification with specific details for how this service is being used.
- CHPI cannot be used for activities included as a part of residential services or setting. This includes activities such as banking, shopping, medical appointments and running errands.
- CHPI needs to be an activity that promotes building relationships, natural supports and participation in activities with non-disabled individuals. This does not mean just being in the community with a staff member.

In many of these situations, it could mean that the service needs to be converted from CHPI to RHS to be more appropriate.

The following RHS questions have been answered and the policy will address the remaining questions.

1. Q: What do you mean by RHS, CMGT, Respite – explore sharing service hrs. among households A: In living arrangements when more than one consumer is residing, case managers and Individual Support Teams need to be looking at how service time can be shared. There are cases where three individuals reside in the same home and have the same case manager. Is it really necessary to have as many hours of CM in this situation? If siblings are receiving services, the Respite hours need to be shared. More RHS hours need to be shared among housemates.
2. Q: When is the effective date for these changes for RHS? A: February 1, 2004.
3. Q: Regarding RHS – What type of revisions are being discussed? A: The RHS policy will be introduced at the December 15, 2003 Provider and Case Manager training.
4. Q: What will become of the people that are in one person settings but require less than 24 hours a day but more than 18 hours of RHS1? A: We would require adequate justification for more than 18 hours in a one-person setting.
5. Q: If you have a 3 person waiver home how many staff hours in a 24 hour day? A: We recommend 40 hours per day of RHS.
6. Q: I would strongly encourage you to consider eliminating RHSD. The majority of CCB updates that I submit are for changes in the RHSD. Every time something changes (e.g.) client gets a job, client loses a job, housemate starts going home overnight on Saturdays, housemate's family decides client can no longer come home for Saturday overnight, etc. it results in a CCB update for the 2 or 3 clients who live in that home because their daily rates are affected. This is a huge waste of money. A: We are considering eliminating the daily rate for RHS and moving to hourly billing.

More clarification on CHP and RHS services will be provided at the training on December 15, 2003.

ICLB Questions:

1. Q: Will there be slots opening up for the T05 clients ICLB to DD Waiver? A: We will continue with the TO5 project, however, we may not be able to move everyone we had previously targeted. We will roll-out the T05 project on December 15, 2003. There may be additional T05 slots that can be filled but there is no estimate of how many, if any at all.
2. Q: What is expected of W198s---will the ICLB be an option? A: Individuals who are cited w198 are considered candidates for a priority waiver. Yes the ICLB is an option.
3. Q: Are ICLB units changing as waivers did? A: Yes, the policies will be applied consistently across waivers and ICLBs.

Case Management:

1. Q: Are there going to be any allowances made for CM's who have to use most of their time fixing "INsite" related issues? Re: incorrect conversions, batch denial of CCB's etc? Either CM units need to be increased or Roeing needs to be financially responsible for the time CMs spend cleaning up their mess. A: If you have an INsite related issue the INsite Help Desk should be contacted. We try to address these questions as quickly as possible to minimize administrative time spent on resolving technical issues.

2. Q: If justification for case management over 6 hours per health and safety needs of a client is provided on a CCB as required by BDDS Bulletin #44 – why are requests for information received asking to reduce the CMGT hours to the 6 hour limitation/month? What standards/guidelines are being reviewed per approval or denial of cmgt over 6 hours? If a MWURequest has been made, then it has not been made clear that the need for additional case management is justified. A: The waiver specialists are looking at what specific activities the case manager is providing; what the expectation is to continue; what is being done to reduce. If you are experiencing on-going difficulties, please contact Lilia Teninty at lteninty@fssa.state.in.us.

Roommates:

1. Q: The question about a roommate going home for the weekend is important for all of us. Please discuss with us all not just the person who wrote the question. A: This will be discussed at the 12/15/03 Provider Training.

2. Q: Problem: 2 housemates. One stays home a lot and would not need a lot of 1:1. But the second person needs a lot of 1:1 to meet her outcomes. How does CM of 1st housemate justify all the 1:1 the first housemate has, just as a result of the 1:1 the 2nd one needs? (Obviously if one housemate requires 1:1 the second gets it by default). A: The housemates would need to have their services designed within the limits for a two person setting. This could mean that not as much 1:1 time will be available. There will be a process for exception under certain circumstances, but it will basically need to be a matter of health and safety needs.

3. Q: If we have clients w/o roommates and they have a year's lease on a one bedroom apt. which most of them do, can we have until the end of the lease to find a roommate? A: will look at this on a case-by-case basis and evaluate the cost benefit of buying out a lease.

4. Q: What kind of transition time is going to be allowed for persons in 1-2 person placements who have just signed leases? Many have already found roommates or they are in the process of looking for a roommate. A: This will be addressed at the December 15 Provider Training.

5. Q: In housemate situations how will appropriate matching work – when one person needs 24 and the other 24? A: This will be addressed at the December 15 Provider Training.

6. Q: Can 2 housemates share staff for 16 hours and then have one-on-one staff for 8 hours each under the new standard? When does this new standard take effect? A: This will be addressed at the December 15 Provider Training.

7. Q: Are there some exceptions made in finding a roommate? Re: Serious health problems? Behaviors? A: Yes, on a case-by-case basis. The state by no means wants to jeopardize the health and safety of anyone.

Miscellaneous Service/Program Issue Questions:

1. Q: Why is the state taking steps that are inevitably going to lead to increased segregation in day services despite what consumers and families are expressing they want in person centered planning?

A: It is not our intention to increase segregation in day services. The policy on day services is being reviewed.

2. Q: CETA & especially FCAR seem to be the most logical services to be eliminated completely on the waiver during this crisis. Why hasn't this been done? A: CETA is currently being reviewed as a service to eliminate.
3. Q: I have submitted all paperwork for; Facilitation and trading partner agreement several, several weeks ago. Whom do I check with regarding status, please give e-mail and phone #. A: Refer to www.indianamedicaid.com
4. Q: Why did the units change? A: This was a requirement of HIPAA National Codes.
5. Q: Why not make them all the same? A: These are established by CMS and BDDS is not able to change.

Budget Questions:

1. Q: If we are to work so hard to contain cost, do you think that the state could work hard at making sure we get paid? At times compensation is running as low as 50% of services rendered. A: If you have a specific billing issue that needs to be resolved please contact EDS directly at 1-800-577-1278.
2. Q: With per diems of over $900 per day for MSDC & $500 per day for FWSDC---what cost saving measures are being implemented to reduce institution costs!!! A: At MSDC, units are being consolidated and staffing is being adjusted based on decreasing census. These are just two examples of attempts to reduce MSDC operating expenses. FWSDC has also closed buildings and units in order to consolidate and improve staffing efficiencies.
3. Q: How can you make guidelines and standards mandatory, yet not be willing to reimburse or pay providers and case managers for services? Even with a contract this is a violation of labor laws – a provider must be paid for services rendered if they are mandatory or required. How are you addressing this issue? A: We pay for case management services on the waiver and we allow for some case management outside the waiver.
4. Q: EDS is denying CETA invoices that are in the budget. Example: tutoring $25 per session, 2X a week = 40 weeks $2,000. Paid $196 but providers want larger invoices less costs to submit. A: If you have a specific waiver billing issue please contact EDS directly at 1-800-577-1278.